GEORGIA DEPARTMENT OF COMMUNITY HEALTH

*Rhonda M. Medows, MD, Commissioner* *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

**September 13, 2007**

**M E M O R A N D U M**

**TO:** **The Board of Community Health**

**FROM:** **Kathy Driggers, Chief, Division of Managed Care and Quality**

**SUBJECT:** **DCH Response to Provider Perspectives**

***Care Management Organizations (CMO) are failing to pay a significant percentage of claims in accordance with the provider contracts they negotiated.***

While we have yet to receive evidence of alleged contract violations, payment compliance with contract terms will be a focus of the audit performed by Myers and Stauffer. It is important to note that the CMOs are not obligated to replicate Medicaid policy or reimbursement rates in their administration of Covered Services; however, in some situations where a CMO has agreed to follow Georgia Department of Community Health (DCH) policy with a hospital, there has been confusion on the interpretation and nuances of our policy, particularly regarding transfers between facilities. We continue to help the CMOs understand DCH policy.

***CMOs are failing to comply with contractual and statutory requirements to pay emergency room (ER) claims in accordance with federal "Prudent Layperson" standard.***

There has been a great deal of commentary from hospitals about the CMOs' "failure to comply with contractual and statutory requirements to pay ER claims in accordance with a federal 'Prudent Layperson' standard." There are some clarifying points to be made:

- Based on the Department's review to date, none of the three CMOs is in violation of either the contract with DCH or the Code of Federal Regulations (§ 483.114) which deals with a Medicaid member's rights to emergency and post-stabilization services

- There is no question that there is a huge amount of ER utilization by Medicaid members for situations better treated in physician offices. This is a behavior that has been learned over time, particularly since the passage of Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986. It is a national problem and not exclusive to Georgia. It is certainly a goal of Georgia Families to reduce this inappropriate utilization, but it will take time to "un-learn" this behavior that has been escalating for 20 years. While all three CMOs currently have strategies in place to reduce their members' use of the ER for non-emergent care, they will all be

implementing Performance Improvement Projects focusing on reducing ER utilization.

Much has been said about both EMTALA and the Prudent Layperson standard. Here is some information about both:

- EMTALA is an anti-discrimination statute passed in 1986 to address the problem of "patient dumping" by hospital ERs, the practice of refusing to provide emergency medical treatment to patients unable to pay. It mandates that emergency care (screening, stabilization and transfer) be offered and conducted without regard to ability to pay when a person has an emergency medical condition which has not been stabilized. EMTALA is indifferent to payment.

- The Prudent Layperson standard is an attempt to objectively define an emergency medical condition by asking the question: would a reasonable person (not the patient) think the condition the patient had was an emergency? The Balanced Budget Act of 1997, which is applicable to Medicare and Medicaid managed care plans, includes Prudent Layperson language but does not specifically define an emergency by diagnosis. It is up to the managed care plan to decide who is a Prudent Layperson and whether this hypothetical reasonable person would think the actual patient's symptoms constituted an emergency. Frequently the coding on the claim does not tell the whole story for Prudent Layperson consideration and thus other documentation needs to be submitted. This does require additional time and effort to ensure that ER claims are paid based emergent versus non-emergent conditions.

- No payor of health care in this country - not Medicare or Medicaid or the federal government, not any large self-insured employers such as Home Depot, Bellsouth, or UPS, not any commercial insurers, and not the State Health Benefit Plan - considers a non-emergent visit to the ER a Covered Service and will pay for it.

- Lastly, DCH has in the past been very broad in its interpretation and payment for ER services. DCH Program Integrity is currently studying Fee-for-Service ER claims from FY06 to determine appropriate payment. This will be used to reconsider DCH ER payment practices.

***There is no evidence that the CMOs are committing sufficient resources to actively manage the care of their enrollees. It is also unclear how the effectiveness of the CMOs case management activities is being evaluated and measured.***

Each CMO has considerable resources devoted to managing their members' care including:

- Member services and outreach representatives
- 24-hour nurse help lines
- Case and disease management staff all of which include nurses and doctors, as well as non-clinical staff

The above mentioned are all resources which were not available to members prior to managed care. This meant that many needs of the member may have been overlooked or mismanaged leading to poor clinical outcomes and member non-compliance.

The effectiveness of the CMOs' case management activities will be evaluated when we look at the results of approximately 30 health care outcomes performance measures in early 2008, as well as through on-site reviews. We will utilize the data from this initial evaluation to prioritize opportunities for improvement and assist in identifying the focus for future interventions. This is how a system of continuous quality improvement really works.

***All three of the CMOs have failed to properly load numerous providers (physicians, clinics, etc.) into their systems, in many cases even one year after contracts were signed.***

While we do not see evidence of large-scale improper loading of providers, we have asked Myers and Stauffer to evaluate the timeliness and accuracy of the provider credentialing and loading process of each CMO.

***All three of the CMOs have failed to comply with section 4.16.2.16 of the DCH - CMO contract, which requires the CMOs Web sites to be "functionally equivalent to the Web site maintained by the state's Medicaid fiscal agent."***

DCH monitors and determines the compliance of the CMOs with all contract terms and conditions, and considers all CMO Web portals compliant with contractual requirements. The ACS Web portal has a popular feature which gives providers the ability to edit and re-submit a claim online. Both Amerigroup and PeachState have instituted this feature on their Web portals; WellCare is continuing Web development work to implement look-up, edit and re-file online.

***The CMOs often fail to comply with section 4.16.1.13 of the DCH – CMO contract which sets forth requirements related to the timely filing of claims by denying claims when the CMO, rather than the provider, was responsible for the filing error.***

DCH has been presented with no evidence of this allegation. All three CMOs have stated that if they have either paid a claim incorrectly or denied it due to their error, they will pay the provider interest on the claim. We have directed Myers and Stauffer to consider this for the audit.

***Hospitals and other providers are routinely denied payments for medically necessary services because of situations beyond the provider's control.***

All the CMOs have indicated that prior authorizations can be updated if a clinician decides to make a change either right before or during the procedure. However, it is incumbent on the provider to let the CMO know if such a change has occurred. A provider's failure to have the appropriate approval for services will most likely result in a claim denial.

***CMO representatives often reference policies and procedures that contradict specific contract terms.***

DCH monitors the provider service levels of all three CMOs. There have been circumstances in which provider representatives, who are otherwise experienced, have been unfamiliar with Medicaid in general and have misquoted or misstated DCH policy. We give feedback to the CMOs when we know of these situations and expect that they educate their provider representatives.

***CMOs' systems and configuration inaccuracies often result in denial of payment or reduced payments to providers.***

The Myers and Stauffer audit will examine the allegation of CMO systems and configuration inaccuracies resulting in inappropriate denials or reductions in provider payments.

***CMOs too often fail to credential providers in a timely manner and to load provider information accurately into their systems.***

The Myers and Stauffer audit will examine the timeliness and accuracy of CMO provider credentialing and loading processes.

***Some CMOS are basing hospital claims submission timeliness on admission date, not discharge date.***

The CMOs are not required to follow DCH policy. Specific procedures for filing claims are outlined in CMO provider manuals.

***Patients can and do change CMOs during an inpatient stay which raises many payment issues. Standard rules should be developed to ensure providers receive payment for medically necessary services provided to the patients.***

Standard rules for payment of hospital inpatient stays during which a member moves from CMO to CMO, or FFS to CMO or vice versa, have been developed and implemented for more than a year.

Newborns are automatically enrolled from birth into the CMO of the head of household of the case (usually the mother). The mother has 90 days from baby's date of birth to choose a different CMO for the baby if she so desires.

***Local CMO representatives (including the local presidents) are not empowered to resolve issues – decisions made at a corporate (national) level may not take into consideration unique local situations and/or factors.***

While it is true that each CMO has corporate policies which provide its structure (as with any other national organizations), there is acknowledgement from the top down that all health care is local. All CMOs have revised many of their policies in order to adapt to the Georgia market.

In closing, DCH has always investigated substantiated complaints or concerns expressed by providers. However, many of the allegations made by providers are anecdotal without solid evidence. When DCH has been presented evidence of errors or issues with policy

interpretation, DCH staff has worked diligently with the CMOs to investigate and resolve the matter. DCH is happy to work with any provider in the investigation of payment errors or policy issues.